UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

Tony Terrell Robinson,

Plaintiff,

v.

Minnesota Department of Corrections, et al.,

Defendants.

Court File No. 17-CV-0437 (DSD/KMM)

DEFENDANT STEPHEN DANNEWITZ, M.D.'S REQUEST FOR PRODUCTION OF MEDICAL TO PLAINTIFF

TO: Plaintiff above named, FCI Greenville, P.O. Box 5000, Greenville, IL 62246.

You are hereby requested, pursuant to Rule 34 of the Federal Rules of Civil Procedure, to furnish to the undersigned attorneys, within thirty (30) days:

a. Copies of all medical reports previously or hereafter made by any treating or examining medical expert; and

b. Written authority, duly signed, permitting the inspection of all hospital and other medical records, concerning your physical, mental or blood condition.

Dated: 7/18/2018

By: _____

Nicole L. Brand (#299546)
Meagher & Geer, PLLP
33 South Sixth Street, Suite 4400
Minneapolis, MN 55402
(612) 338-0661
nbrand@meagher.com

Attorneys for Defendant Stephen Dannewitz, M.D.

12288121.1

AUTHORIZATION FOR RELEASE, USE AND DISCLOSURE OF MEDICAL INFORMATION

Patient: Tony Terrell Robinson

DOB:

This will authorize _____ to release to Meagher & Geer, P.L.L.P., 33 South Sixth Street, Suite 4400, Minneapolis, Minnesota 55402, or their agents/representatives, any and all information from the medical records, lab work and radiology images obtained while I was a patient at said facility during any and all times.

The information to be disclosed is: Certified copies of any and all medical records and radiology images without limitation including psychiatric, alcohol/substance abuse, HIV/AIDS, or mental health counseling records, and/or billing records that are part of the records for all dates.

Purpose of the use and disclosure: Litigation.

I understand the use and disclosure of my individually identifiable health information as described above. I understand this authorization is voluntary. I understand if the person or organization I authorize to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and could be re-disclosed. I understand that my health care and payment for my health care will not be affected if I do not sign this form.

I understand that I may revoke this consent by written request at any time to the address listed above, except to the extent action has already been taken in reliance on it, and that upon fulfillment of the above-stated purpose, this consent will automatically expire without my express revocation 12 months from the date of signing. I also understand that I have a right to receive a copy of this authorization.

A photocopy or fax of this authorization shall be as valid and treated in the same manner as the original hereof signed by me. This authorization specifically allows disclosure of records dated both before and after the date of this authorization up to the date that the authorization expires.

_____

(Signature of Patient/Guardian) Date

_____

(Relationship to Patient If Guardian)

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(Reason Patient Unable to Sign)

45 C.F.R. Part 164, Minn. Stat. § 144.293

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